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**FEMALE CONDOM ACCEPTABILITY
AMONG FAMILY PLANNING
CLIENTS OF BLANTYRE CITY**



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***FEMALE CONDOM ACCEPTABILITY
AMONG FAMILY PLANNING CLIENTS
OF BLANTYRE CITY***

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EXECUTIVE SUMMARY

Objectives of Study

A study on the acceptability of female condoms among family planning clients was conducted in Blantyre, Malawi from October 1995 to September 1996. The objectives of the study were the following:

- a. Determine the effects of counselling which specifically emphasizes barrier methods on the rate at which clients take home from family planning clinics male and/or female condoms.
- b. Determine the effects of the introduction of the female condom, in addition to the male condoms offered all new clients, on the overall prevalence and continuation rates of barrier contraceptive use.
- c. Compare the rate and experiences of male and female condom use among clients who frequent the family planning clients.
- d. Compare the continuation rates of all the contraceptives offered in the three clinics.

Methodology

An experimental study was implemented in which three family planning clinics were selected which had the highest client attendance in Blantyre. In the first female condoms were introduced and both male and female condoms were strongly promoted in addition to the usual contraceptives dispenses. The second clinic strongly promoted male condoms in addition to usual contraceptives and the third clinic was a control. Data was obtained from client records for one year. A total of 322 exit interviews were collected immediately after first time family planning consultations with all clients who took home male and/or female condoms and 294 follow-up interviews were made of the same clients from the two experimental clinics.

In those clinics the family planning providers were given a two-day training to up-date their contraceptive knowledge including the female condom and their skills in motivating and counselling clients with special emphasis put on providing clients with information on condoms.

Data was analyzed using SPSS Version 6 for ANOVA. Means were separated by the Duncan Multiple Range Test.

This paper is based on the data collected from the clinic records of the experimental clinics and on data from 322 exit interviews and 294 follow-up interviews from clients from the one clinic where female condoms were distributed.

Major Findings

1. Counselling emphasizing barrier methods tended to increase the number of clients who took home barrier methods. A significantly higher rate ($P=.008$) of new clients took home barrier methods in each intervention clinic than in the control clinic.

2. The introduction of the female condom, in addition to the male condoms offered all new clients did not increase the overall prevalence and continuation rates of barrier contraceptive use. In the two intervention clinics there was a statistically significant higher percent ($p=.008$) of new clients who took home barrier methods than those who had taken home barrier methods in the control clinic but there was not a significant difference between the two intervention clinics.

3. Of the clients who took condoms home, a higher percentage who took male condoms used them than those who took the female condoms. Both types of condoms were mainly given as a back-up method for the first two weeks of use of hormonal methods. More types of favorable experiences with male condoms were reported than with female condoms. Of those who took the female condom home and used it, the majority did not like it because it interfered with the natural feeling during sexual intercourse. A similar reason was cited of the male condom. The most commonly cited reasons for not choosing the female condom included discomfort with the structure, shape and size, and the male partners refusal to use it. There was a very high discontinuation rate of both types of condoms as well as the preferred hormonal contraceptives.

4. The continuation rates of all contraceptives was very low and only one client came back to the clinic to get more female condoms. There was a large decline in percentages of clients who made their resupply visit in all the clinics from the first to the fourth visit. By the end of the study year only 8.3% of all clients from all three clinics returned.

Conclusion

The study suggested three major factors which influenced the low acceptance of female condoms among family planning clients: 1. The current low rate of modern contraceptive prevalence and continuation rates which make it difficult to introduce any new modern contraceptive; 2. The current stigma attached to male condoms which has been attributed to female condoms as well; 3. Male dominance between husbands and wives over sexual matters including contraception which results in the need for the husbands approval for the wife to use the female condom. Although there was low acceptance by the clients of the female condom further consideration of its introduction is important because it would add an additional resource for STD/HIV protection.

Recommendations

1. Refresher courses for family planning providers with special emphasis on the importance of condoms followed by supervision.
2. Development of negotiation skills of wives over sexual issues.
3. Involvement of men in family planning through "male friendly" clinics with counseling of both spouses.
4. Development of a multi-faceted approach to target men for sexual and contraceptive education.
5. Introduction of female condoms in family planning clinics in conjunction with depots targeting special populations.

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I. INTRODUCTION

HIV/AIDS is a major health problem in Malawi. According to the 1995 AIDS Cases Surveillance report (1995:AIDS Secretariat), women in the age bracket of 20 to 24 years are three times as likely to be seropositive than their male counterparts. To date the male condom is the only available self-protective device against sexually transmitted diseases (STDs). This study was conducted to ascertain the acceptability of the female condom as a protective device against STDs and as a barrier method of contraception in comparison to other forms of contraceptives. This data will assist the manufacturers and donor agencies to make pertinent program and policy decisions regarding the usefulness of female condoms in developing countries and the need and extent to which its market cost could be subsidized. Further, it will provide information necessary for the consideration of the female condom to be introduced as part of the contraceptive method mix distributed in family planning clinics.

A. Objectives

The overall objective of the study was to ascertain the acceptability of the female condoms among women who attend urban family planning clinics. The data provided in this report is only part of the total study data and it was drawn from the family planning clinics which promoted the female and male condoms. The following specific objectives were addressed:

- a. Determine the effects of counselling which specifically emphasizes barrier methods on the rate of both male and female condom use.
- b. Determine the effects of the introduction of the female condom, in addition to the male condoms offered all new clients, on the overall prevalence and continuation rates of barrier contraceptive use.
- c. Compare the rate and experiences of male and female condom use among clients who frequent the family planning clinics.
- d. Compare the continuation rates of all the contraceptives offered in the three clinics.

B. Methodology

In order to compare the effects of improved condom counselling and the introduction of female condoms on the rate of use of barrier methods, an experimental study was designed.

Three government family planning clinics were selected in Blantyre which had the highest client attendance in the city. In clinic A, female condoms were introduced and both male and female condoms were strongly promoted in addition to the usual contraceptives dispensed.¹ Clinic B, strongly promoted male condoms in addition to usual contraceptives and clinic C, was used as a control.

During the study intervention period, the family planning providers were instructed to change their usual order of contraceptive presentation when counseling clients and start with condoms rather than hormonal contraceptives (Appendix 1). In clinic A, they were to first introduce female and then male condoms, and in clinic B, only the male condoms were introduced. Rather than presenting condoms mainly as a back-up method, which they habitually did, the family planning providers were instructed to emphasize condom use as an STD and HIV/AIDS preventive measure as well as an effective contraceptive, especially when used with spermicide. Normally available in all three clinics were low dosage combined progesterone and estrogen pills, progesterone only pills, Depo-Provera, Intra-uterine device (IUCD), and male condoms. Only clinic A provided Norplant.

Data were obtained from client records for one year from October, 1995 to September, 1996. This included baseline data for the first three months before the interventions were implemented as well as during the nine month intervention period. The target population was all new family planning clients registered in the three clinics during this period which totaled 3,471.

The experiences of clients with barrier methods was obtained from those first time clients who took home male or female condoms from clinics A, and B, and were willing to be interviewed. A total of 753 clients were interviewed after their first visit, 446 were from Clinic A, and 307 from Clinic B. Of those participating in the first interview, 401 were interviewed a second time, 297 from Clinic A, and 104 from Clinic B.

In the two clinics where the interventions took place, two questionnaires were administered to first time clients. They contained both closed and open-ended in-depth questions. Exit interviews were conducted immediately after the clients' initial consultation to determine their knowledge of contraceptives and to obtain their sexual history. To determine the clients' experiences with the male and female condoms, as well as their awareness of the HIV/AIDS epidemic, follow-up interviews were conducted of the same clients either at the clinic after their second consultation, or at their homes if they did not return to the clinic.

¹The reason for making female condoms available in only one clinic was that if clients had accepted the female condom to use every time they had intercourse, then the 5,000 supplied for the study would have been enough for only 50 women over a period of 6 months.

In the two intervention clinics family planning providers were given a two-day training to refresh their knowledge of contraceptives and update their skills in motivating and counselling clients. When the baseline data were being collected from the clinic register books it was discovered that the service providers did not consistently register condom distribution. In most instances the providers only recorded the distribution of the hormonal contraceptives and omitted the condoms, especially when they were only given as a back-up method. The research assistants were therefore instructed to review the clinic records with the service providers and requested them to register all condoms distributed. During the course of the study several supervisory visits were made to ensure that the service providers were giving the information as instructed.

To understand the responses to the introduction of the female condom, it is necessary to understand the context in which it was introduced. One important aspect is the general acceptability of any contraceptive at the time of the study. To do this, the continuation rates of all contraceptives used by clients in the three clinics were calculated.

Data were analyzed using the SPSS Version 6 statistical package, and a part from descriptive statistics, tests such as ANOVA and Duncan Multiple Range Test were conducted.

II. FINDINGS

The findings being presented are based on client contraceptive records which were kept over the year of the study in the three clinics, and the initial and follow up interviews of the clients in clinic A who took home female and/or male condoms.

The study findings will be presented under the following headings: a. demographic data, b. effects of improved condom counselling on the rate of male and female condom use, c. effects of the introduction of the female condom on the overall prevalence and continuation rates of barrier contraceptives, d. experiences with male and female condoms.

A. Demographic data

During the study period, a total of 3,469 new family planning clients were registered at the three clinics. 92.5% (n= 3,199) of these new clients were married, 6.2% (n= 214) were single and the remaining 1.3% (n= 46) were either widowed, divorced or cohabiting. It is possible that some single women registered themselves as married because formerly only married women were allowed to request contraceptives in the clinic.

1. Age

The age of new clients who registered at the clinic which promoted both male and female condoms ranged from 16 to 45 years. The table 1. below shows the age distribution of the clients.

TABLE 1. Age distribution of clients

AGE BRACKET	CLINIC A		CLINIC B		CLINIC C	
	No.	%	No.	%	No.	%
16-20 years	369	19.6%	226	20.9%	132	26.1%
21-25 years	768	40.7%	441	40.8%	199	39.4%
26-30 years	442	23.5%	212	19.6%	93	18.4%
31-35 years	204	10.8%	126	11.7%	51	10.1%
36-40 years	69	3.7%	52	4.8%	20	4.0%
41-45 years	26	1.4%	23	2.1%	9	1.8%
Missing	5	0.3%	1	0.1%	1	0.2%
TOTAL	1883	100.0%	1081	100%	505	100%

These data indicate that in all the three clinics the majority of the new clients were between 16 and 30 years old, which is the age of high sexual activity and peak child bearing . 84.1%, (n= 1,579) in Clinic A., 81.4% (n= 879) in Clinic B. and 84.1% (n= 424) in Clinic C. Only 5.7% (n= 199) of the new clients were over 35 years of age. This may be because at this age they are less sexually active or are passing over child bearing age and think they have no need for contraception. Or because, older women are following a cultural norm which require that once one is a grandmother, she should cease to have sexual intercourse. It may also be a result of less knowledge about contraceptives than the younger women as family planning has only recently been vigorously promoted in Malawi.

2. Educational level

The educational level of clients who attended the family planning clinic which promoted both female and male condoms ranged from none to college. In clinics A, B, and C respectively 9%, 12.3% and 14.3% had no formal education. In all clinics the largest percentage of clients had some primary education, 54.6%, 71.7% and 61.1% in Clinics A, B, and C respectively. Few clients had secondary education, 32.9%, 13.8% and 23% in Clinics respectively. Only 2.3%, 0% and .4% had any university level education in Clinics A, B, and C respectively. Clinic A had a clientele with somewhat of a higher educational level than the other two. This may be because it is attached to the major hospital in the city and has a much wider range of clients in its catchment area than the other two clinics. Table 2. presents the formal educational level of the clients.

TABLE 2. Educational level of clients

EDUCATIONAL LEVEL	CLINIC A		CLINIC B		CLINIC C	
	No.	%	No.	%	No.	%
None	170	9.0%	133	12.3%	72	14.3%
Junior primary	291	15.5%	181	16.7%	79	15.6%
Senior primary	736	39.1%	595	55.0%	230	45.5%
Junior secondary	237	12.6%	92	8.5%	67	13.3%
Senior secondary	382	20.3%	57	5.3%	49	9.7%
University/college	48	2.5%	0	0.0%	2	0.4%
Missing	19	1.0%	23	2.1%	6	1.2%
TOTAL	1,883	100.0%	1,081	100.0%	505	100.0%

B. Effects of improved condom counselling on the rate of male and female condom use

It was hypothesized that if special emphasis was put on both male and female condoms during family planning counselling there would be an increase in the percentage of new clients who took home condoms. This hypothesis was confirmed. A significantly higher rate ($P=.008$) of new clients took home barrier methods in each intervention clinic than in the control clinic. Over a six month period, in clinic A, where both male and female condoms were distributed, 46.25% of new clients took home condoms, and in clinic B, where only male condoms were distributed, 43.60% of new clients took home male condoms. During that same period of time, in the control clinic only 17.40% of new clients took home male condoms.

Table 3. Percentage of clients who took home condoms in the three clinics

Clinic	Percent of clients
Clinic A: (male & female condoms)	46.25%
Clinic B: (male condoms)	43.60%
Clinic C: (control clinic)	17.40%

C. Effects of the introduction of the female condom on the overall prevalence and continuation rates of barrier contraceptives (male and female condoms)

It was hypothesized that if the female condom were introduced, in addition to the male condom, then the total number (and percentage) of clients using barrier methods (either male or female condoms) would increase. This was not confirmed. To test the hypothesis, a comparison was made between the percentage of new clients who took home barrier methods in the three clinics during the six months when female condoms were distributed. It was found that the two intervention clinics had a statistically significant higher percentage ($P=.008$) of new clients who took home barrier methods than the new clients who had taken home barrier methods in the control clinic. But, there was no statistically significant difference between the two intervention clinics. Therefore, the introduction of the female condom created no increase in barrier method use.

Out of 1,178 new clients registered at clinic A, 9.9% ($n= 117$) took female condoms home. Exit interviews were conducted of all of these clients. Of those 84.6% ($n=99$) participated in follow-up interviews. Data from the follow-up interviews indicated that of those clients who took the female condom home, 73.5% ($n= 86$) used them. 11% ($n= 13$) returned the condoms to the clinic because they did not use them, and the remaining 15.5% ($n= 18$) either had not used the condoms yet, or did not come back to the clinic or could not be traced. Only one client had continued to consistently use both the female and male condoms because she had severe side effects on both hormonal contraceptives and the intra-uterine contraceptive device.

Table 4. Clients who took home female and male condoms from clinic A

Activity	Female Condom	Male Condom
Took condoms home	117	432
Provided exit interviews	117 (100%)	205 (47.5%)
Reported having used condoms	86 (73.5%)	171 (83%)
Returned condoms unused	13 (11%)	24 (11.7%)
Could not be traced	18 (15.5%)	10 (4.9%)

Of the new registered clients in clinic A., 36.7% ($n= 432$) took the male condoms home. Exit interviews were conducted of 47.5% ($n= 205$) of these clients. Of those clients 95% ($n=195$) participated in follow-up interviews. 83% ($n= 171$) used them, 11.7% ($n= 24$) reported not having used them, and the remaining 4.9%

(n= 10) did not come back to the clinic and could not be traced. The breakdown of clients who took home condoms is provided in Table 4.

These data show that more clients took home the male than the female condom. Of the clients who took condoms home, a higher percentage of those clients who took the male condoms used them than those who took the female condoms. Both the male and female condoms were mainly given as a back-up method to use for the first two weeks of use of Depo-Provera or oral contraceptives.

D. Clients' experiences with male and female condoms

The results of the follow-up interviews with clients from clinic A indicated that male condoms were favored over female condoms. The clients were asked to state what they liked and did not like about their experience of using male and/or female condoms. Each client gave several responses. Of the 1,765 responses concerning the attitude toward male condoms, 55.9% (n=985) were positive and 44.1% (n=780) were negative. On the other hand, for the female condoms, of 703 responses concerning attitudes, only 39.7% were positive and 60.3% (n=424) were negative. The following are examples of those experiences with the male and female condom.

1. Female Condoms

A few of the examples of positive experiences of the female condom included the following:

- a. It is convenient in that a woman can use it if the man cannot use male condoms.
- b. It is reliable since it protects one from contracting STDs and pregnancy because of thick texture.
- c. Provides clean sex since the body does not come in contact with semen.
- d. Delays orgasm and the women liked this because it gave them time for sexual play.

The negative experiences reported included the following:

- a. There is only one size and it fits too loosely in some people resulting in lack of sexual pleasure.
- b. The internal ring causes pain to the man during sexual intercourse.
- c. It takes the man too long to ejaculate which results in the couple working too hard to reach the climax. Some clients experienced sore genitalia.
- d. The condom's outer ring prevents the penis from deep penetration.
- e. The process of inserting the condom is too involving.

- f. The clients were also put off by the shape and structure of the condom and the fact that it cannot be re-used.

The above lists of experiences indicates that one reaction to female condom use, delay in orgasm, was interpreted as negative by some and positive by others. This is a good example of how the same experiences are perceived differently by different people.

In the process of actually using the female condom, some women inserted it themselves and some had their husbands insert it. Of those who inserted it themselves, some did so in full view of their husbands and some in private. The fact that some husbands inserted the female condoms for their wives indicates that it could be part of foreplay and thus contribute to sexual pleasure. Since many houses of these clients do not have a private room other than the bedroom where the client could insert the female condom, it is important that some women were willing to insert it in view of their husband.

The majority of the clients' spouses were not very enthusiastic about the female condom. One reason cited for not using the female condoms was that their husbands refused and preferred that their wives use other forms of contraceptives. The major reason given was that the condom interfered with their natural sexual pleasure. The few male partners who were interviewed emphasized this as a major factor contributing to couples' dislike of either type of condoms.

The data also suggests that the choice of condom use was influenced by a prevailing custom of sexual dominance of husbands over wives. For example, one of the client's interviewed reported that after suggesting the use of the female condoms to her husband, he sent her back home to her village to explain to her *Ankhoswe* (traditional marriage counsellor/advocate) about using condoms in the family since this was not part of their advice at the time of marriage. The *Ankhoswe* directed her to obey her husband.

2. Male Condoms

Those clients who used male condoms reported both positive and negative experiences. The reports of experiences with the male condoms were similar to those already reported in other studies in Malawi (1996: Kornfield and Banda, 1996: Namate and Kornfield, 1995: PSI).

The positive experiences included the following:

- a. It is convenient in that it makes intercourse possible even during times of sexual abstinence such as during menstruation.
- b. The design is simple and acceptable to both spouses.

- c. Provides clean sex since the body does not come in contact with semen.

The negative experiences included the following:

- a. There is a tendency for the male condom to burst.
- b. The lubricant used in the male condom has a bad odour.
- c. Having to remove it and putting on a clean one with every sexual act is an inconvenience.
- d. It reduces sexual pleasure.
- e. It delays ejaculation.
- f. The rubber causes skin reaction with resultant sore around the genitalia.
- g. It is difficult for a woman to convince a man to use the male condom because it is controlled by him.

Note that some of the experiences with male condoms were the same as female condoms, for example they delay ejaculation and reduce sexual pleasure. Also, it was difficult for the women to convince their spouses to use either male or female condoms.

E. Contraceptive continuation rates during the study period

Table 5 shows the distribution of all contraceptives by client. Table 6 show the distribution of the three major contraceptives, Depo-Provera, pills and condoms. There was no significant difference in the pattern of distribution of the three major contraceptives, Depo-Provera, pills and condoms among the three clinics. However, there was a significant difference between the distribution of Depo-Provera in all three clinics respectively, as compared to pills and condoms. ($P=0.0023$) In all three clinics, the majority of clients used hormonal contraceptives with a strong bias toward Depo-Provera. Depo-Provera was used in Clinic A by 63% ($n=1,187$) of the clients, in Clinic B by 76.3% ($n=825$) of the clients, and in Clinic C by 77.4% ($n=391$) of the clients. Pills were used respectively in Clinics A, B and C by 27.1% ($n=510$), 22.3% ($n=241$) and 16.8% ($n=85$) of the clients.

Table 5. Contraceptive distribution by clinic for year of study

METHODS ACCEPTED	CLINIC A		CLINIC B		CLINIC C	
	No.	%	No.	%	No.	%
PILL ONLY	260	13.8	109	10.1	57	11.3
-MALE CONDOM	202	10.7	105	9.7	28	5.5
+SPERMICIDES	4	0.2	25	2.3	0	0.0
+FEMALE CONDOM	17	0.9	0	0.0	0	0.0
-FEMALE CONDOM+SPERMICIDES	3	0.2	0	0.0	0	0.0
-MALE CONDOM+SPERMICIDES	24	1.3	2	0.2	0	0.0
TOTAL FOR PILL	510	27.1	241	22.3	85	16.8
MALE CONDOM ONLY	14	0.7	2	0.2	20	4.0
DEPO-PROVERA ONLY	605	32.1	436	40.3	354	70.1
-MALE CONDOM	463	24.5	263	24.3	30	5.9
-SPERMICIDES	8	0.4	121	11.2	6	1.2
-MALE CONDOM+SPERMICIDES	37	2.0	5	0.5	1	0.2
-FEMALE CONDOM	65	3.5	0	0.0	0	0.0
-FEMALE-MALE CONDOM	6	0.3	0	0.0	0	0.0
-FEMALE CONDOM-SPERMICIDES	3	0.2	0	0.0	0	0.0
TOTAL FOR DEPO-PROVERA	1187	63.0	825	76.3	391	77.4
NORPLANT ONLY	100	5.3	1	0.1	0	0.0
-MALE CONDOM	5	0.3	1	0.1	0	0.0
-FEMALE CONDOM	3	0.2	0	0.0	0	0.0
-MALE CONDOM-SPERMICIDES	1	0.1	0	0.0	0	0.0
SPERMICIDES ONLY	1	0.1	0	0.0	2	0.4
IUCD ONLY	22	1.2	3	0.3	0	0.0
+MALE CONDOM	2	0.1	4	0.4	0	0.0
FEMALE CONDOM ONLY	6	0.3	0	0.0	0	0.0
-SPERMICIDES	9	0.5	0	0.0	0	0.0
-MALE CONDOM	3	0.2	0	0.0	0	0.0
-MALE CONDOM-SPERMICIDES	1	0.1	0	0.0	0	0.0
MALE CONDOM-SPERMICIDES	14	0.7	2	0.2	1	0.2
PILL - DEPO-PROVERA	0	0.0	1	0.1	0	0.0
NO METHOD (missing)	5	0.3	1	0.1	6	1.2
TOTAL CLIENTS	1883	100	1081	100	505	100

Table 6. Client use of condom, pill and Depo-Provera*

	CONDOM		PILL		DEPO-PROVERA	
	No.	%	No.	%	No.	%
CLINIC A	862	45.8	510	27.1	1187	63.0
CLINIC B	384	35.5	240	22.2	825	76.3
CLINIC C	80	15.8	85	16.8	391	77.4

*Note: Clients took condom, pill and Depo-Provera as individual or in combination with another method. Percent is based on total of first visit of clients within the clinic during this study year. (Clinic A. n=1883) (Clinic B. n=1081) (Clinic C. n=505)

Female condoms were taken home in clinic A. by 5.46% (103) of the clients. All these clients, but six, took the female condoms home in combination with other methods, mainly hormonal. Male condoms were taken home, respectively in Clinics A. by 40.46% (n= 762), in Clinic B. by 35.52% (n= 384) and in Clinic C. by 15.84% (n= 80) of the clients. Male condoms were mainly taken home in conjunction with other methods, especially hormonal. Male condoms, alone were taken home by 0.7% (n= 14) of the clients, 0.2% (n= 2) of the clients and 4% (n= 20) of the clients in Clinics A, B and C respectively.

Table 7. shows the percentages of resupply visits made or not made of all the new clients who registered at the three clinics during the year of the study. From the table it can be seen that there was a large decline in percentages of clients who made their resupply visit in all the clinics from the first to the fourth visit. Between the first and third visits there was a consistent decline in percentages of clients who kept their appointments in all the clinics with a very drastic decline between the third and fourth visits. While the percentages of those who kept their appointments declined, the percentages of those who did not keep their appointments consistently increased from visit to visit in all three clinics. There were only minimal differences in percentages of appointments kept and not kept among the three clinics. Of the total number of clients, only 13.24% (n=49) continued using contraceptives for an entire year while 86.76% (n=321) discontinued .

In Clinic A, 1,456 clients were due for a first appointment. Of these 64.53% (n=946) returned and 35.47% (n=520) did not. Of the 946 clients due for a second resupply visit 46.6% (n= 441) returned and 53.40% (n=505) did not. Of the 441 clients due for a third visit, 41.72% (n=184) returned and 58.28% (n=257) did not. Of the 184 due for a fourth visit, 17.93% (n=33) returned and 82.07% (n=157) did not.

In Clinic B, 819 clients were due for a first appointment. Of these 66.54% (n=545) returned and 33.46% (n=274) did not. Of the 545 clients due for a second

resupply visit 52.84 (n= 288) returned and 47.16% (n=257) did not. Of the 288 clients due for a third visit, 40.97% (n=118) returned and 59.03% (n=170) did not. Of the 118 due for a fourth visit, 7.63% (n=9) returned and 92.37% (n=109) did not.

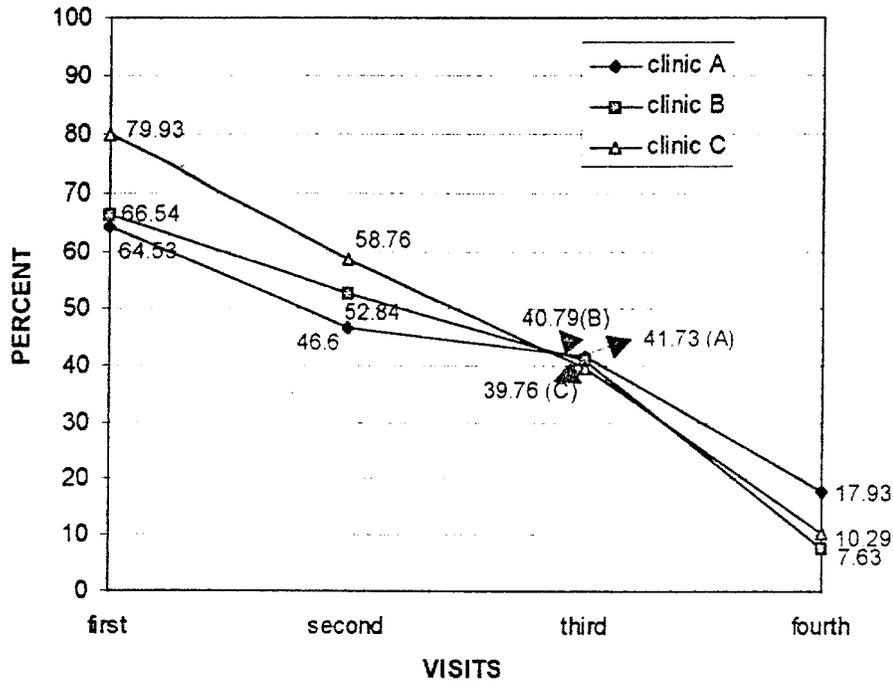
In Clinic C, 365 clients were due for a first appointment. Of these 79.93% (n=291) returned and 20.27% (n=74) did not. Of the 291 clients due for a second resupply visit 58.76 (n= 171) returned and 41.24% (n=120) did not. Of the 171 clients due for a third visit, 39.76% (n=68) returned and 60.24% (n=103) did not. Of the 68 due for a fourth visit, 10.29% (n=7) returned and 89.71% (n=61) did not.

Table 7. Re-supply visits of new clients for all contraceptives in all three clinics

	Revisit	First	Second	Third	Fourth
Clinic A	Appt's due	1466	946	441	184
	return	64.53% (n=946)	46.6% (n=441)	41.72% (n=184)	17.93% (n=33)
	no return	35.47% (n=520)	53.40% (n=505)	58.28% (n=257)	82.07% (n=151)
Clinic B	Appt's due	819	545	288	118
	return	66.54% n=545	52.84% n=288	40.97% n=118	7.63% n=9
	no return	33.46% n=274	47.16% n=257	59.03% n=170	92.37% n=109
Clinic C	Appt's due	365	291	171	68
	return	79.93% n=291	58.76% n=171	39.76% n=68	10.29% n=7
	no return	20.27% n=74	41.24% n=120	60.24% n=103	89.71% n=61
Total	Appt's due	2650	1782	900	370
	return	67.25% n=1782	50.51% n=900	41.12% n=370	13.24% n=49
	no return	32.75% n=868	49.49% n=882	58.88% n=530	86.76% n=321

Figure 1 below illustrates the similarities in the pattern of the declining return rate of the clients in Clinics A, B, and C from the first to the fourth visit.

FIGURE 1: RESUPPLY VISITS OF NEW CLIENTS FOR ALL CONTRACEPTIVES IN ALL THREE CLINICS



The percentage of clients continuing to use any contraceptive in the three clinics was very low as indicated in Table 8.

Table 8. Number of clients still continuing on contraceptives at one year from commencement of study

	First 3 months of study	At one year	percentage continuing at one year
Clinic A.	209	33	15.79%
Clinic B.	248	9	3.62%
Clinic C.	133	7	5.29%
Total	590	49	8.30%

Clinic B. and C. had a much lower percentage of continuing clients at one year than Clinic A. At Clinic A. the percentage of clients continuing was 15.79%, at Clinic B. it

was 3.62%, and at Clinic C. it was 5.29%. In the two intervention clinics, A and B, there was a large difference, whereas between Clinic B. and Clinic C. the control clinic, there was little difference.

In the Clinic A, where the female condoms were distributed, the continuation rate for all contraceptives decreased from 61.91% of the clients who came back for their first appointment to 4.57% (n=33) of those who came back for their fourth. 90.1% of the clients were using Depo-Provera or oral contraceptives. This indicates that women who began using effective contraceptives stopped using them within a year even when they were available at a clinic close to their residence. As mentioned above the continuation rates for the female condom were almost zero except for one client who continued using them because she could not use hormonal contraceptives for medical reasons.

III. DISCUSSION

A. Reasons for low acceptance of female condoms

This study indicated that the female condom was not accepted by the urban married family planning clients in the largest clinic in Malawi. There may be several reasons for this other than the immediate experience of using something new and unfamiliar for the first time.

1. Overall low acceptance of contraceptives including male condoms

It may be due to the overall opinion of family planning in Malawi where contraceptives in general and especially barrier methods have not been accepted. According to the 1989 Malawi DHS, the national modern contraceptive rate is 7.4%. In addition, the contraceptive continuation rates are extremely low. Therefore introducing a new method as part of the contraceptive method mix offered in family planning clinics would probably be as difficult as it has been introducing all the others.

2. Stigma attached to male condoms attributed to female condoms

Already in Malawi, the male condom is very unpopular among married couples as it carries the stigma of being associated with prostitution and extramarital sex. (1996:Namate and Kornfield, 1996:Kornfield) The data strongly suggested that the female condom may carry with it this same stigma. Therefore since the introduction of any method has been very slow and difficult, and a negative stigma associated with male condoms has been applied to the female condom, the introduction of female condoms would be extremely difficult.

3. Negative attitude towards any condoms by family planning providers

A generally negative attitude toward condoms by family planning providers could have contributed to the low acceptance rate of both female and male condoms. Although the study indicated that better counselling emphasizing the importance of condoms for prevention of pregnancy and HIV/AIDS increased the percentage of new clients who took home barrier methods, the continuation rates were extremely low. Also, most of the clients who used condoms only used them as a back up method.

Even though service providers in both intervention clinics, in addition to their refresher course, were supervised and given feedback on the importance of stressing the use of condoms as both an effective contraceptive and HIV/AIDS and STD preventative, they were very resistant to do so. This may be because the service providers, themselves, had the same negative attitudes towards condoms as the clients had, as observed by the researchers. This negative attitude is corroborated by other studies in Malawi (1996: Namate and Kornfield; 1995: Tavro, Namate, and Mpemba). They suggest that service providers in Malawi consider the condom with the same stigma as do their clients and frequently present condom information in a biased manner.

4. Male dominance of husbands over wives concerning sexual matters

The male dominance of husbands over wives concerning sexual matters had a strong influence over the acceptance or non-acceptance of male or female condoms. As long as the male sexual partner dominated, as indicated by this study, and the women had such a hard time convincing their husbands to use any contraceptive and especially condoms, then their suggestion to use female condoms would be received no differently. This lack of female sexual empowerment had important consequences for female condom use. The data suggested that if the husband wanted to use the male condom and the wife did not, she still would have sexual intercourse for fear that her husband would go to another woman if she refused. Further, if she insisted on using the female condom when her husband did not want her to, then he refused to have sex with her and again the wife feared that her husband would go to other women to satisfy his sexual needs.

Thus the women are in a bind. As assertive and insistent they may be, the threat of their husbands simply finding other sexual partners is very real and sufficient to cause the wife to go along with her husband no matter how she feels. This suggests that until the men change their attitudes and actions, the women will not be able to gain sexual empowerment over their husbands or other sexual partners. And, this means that the female condom, itself, cannot be a means of sexual empowerment. First the men must be willing to relinquish some of their sexual dominance and accept the desires of their wives, before the wives will be able to have any influence over

their sexual relations with their husbands. The same goes for prostitutes or unmarried women desiring sexual activity, as the men simply go to other women when a prostitute or a woman friend insists on using a condom when he does not want to.

There has been discussion that female condoms have an advantage over male condoms in that the woman would have control and would be able to use them even if her sexual partner did not want to. However, evidence from this study suggests that use of female condoms did not empower the woman vis-à-vis her husband during their sexual relations. According to descriptions of the way they were inserted, how they fit, and the process of the husband's penis entering the vagina through the condom, the husband would necessarily know if his wife was using the condom and would be required to adjust to its use as well. Also in the cases where their husbands refused to use the female condoms the wives did not insert it even when she wanted to.

There is evidence in Malawi that women do use Depo-Provera secretly when they know that their husband would disapprove of contraceptive use. (1996:Kornfield and Banda; 1994:Tavrow, Namate and Mpemba) Therefore, it appears, that for married women, a contraceptive in the form of an injection may be more empowering than one in which the sexual partner participates such as male and female condoms. However, contraceptive use in secret is not indicative of the sexual influence of the wife over her husband.

B. Indications of acceptance of female condoms

The fact that there were some positive responses to the female condom in the study population suggests that it is not completely unacceptable. As attitudes change towards contraception and male condoms, the attitude toward the female condom may change also.

There are some indications that other social categories of women besides married family planning clients may be interested in the use of female condoms, commercial sex workers and HIV infected women. A previous female condom acceptability study was conducted in Malawi among commercial sex workers which suggested their interest in female condoms. However, it is possible that the selection of the study subjects was biased as only those who were interested in the female condom requested to be enrolled in the study. Also return rates were not measured therefore it is not known whether those giving positive accounts of their experiences would continue use.

At the first "National Conference on AIDS in Malawi" held in September 1996, a group of women who were members of People Living with AIDS (PWAs) reported that they had used female condoms and had gone all the way to Zimbabwe to get them.

IV. CONCLUSION AND RECOMMENDATIONS

A. Conclusion

The study suggested three major factors which influenced the low acceptance of female condoms among family planning clients: 1. The current low rate of modern contraceptive prevalence and continuation rates which make it difficult to introduce any new modern contraceptive; 2. The current stigma attached to male condoms which has been attributed to female condoms as well; 3. Male dominance between husbands and wives over sexual matters including contraception which results in the need for the husbands approval for the wife to use the female condom.

While this study indicated a low acceptance rate among urban family planning clients in the largest clinic in Malawi, this is not sufficient evidence to generalize a strong lack of acceptance to family planning clients in the entire country. Also, as there is other evidence of acceptance of female condoms by special populations such as women living with AIDS and commercial sex workers, it would be premature to suggest no further interest in the introduction of the female condom.

As the female condom would add an additional resource for STD/HIV protection were it used, further consideration of its introduction is important, especially noting that before any contraceptive has ever been accepted much public education as well as its availability has been necessary. However, all of the factors discussed above must be taken into account if the female condom is to be introduced successfully. In addition, it will be necessary to provide female condoms either free and/or at an affordable price for the majority of the population as are the other contraceptives. With this in mind the following recommendations are made.

B. Recommendations

- 1. Refresher courses for family planning providers with special emphasis on the importance of condoms followed by supervision**

The fact that improved counselling can positively influence condom use suggests that family planning provider refresher courses with special emphasis on condom use as was done for this study are a useful method for increasing condom use. The study demonstrated, though, that after the refresher course much supervision with direct feedback to the provider is necessary. In addition, the service providers still need more education to 1) understand the importance of recommending condoms as more than just a back-up method, 2) recognize the importance of the consistent and continued use of condoms as both a viable contraceptive and STD, HIV/AIDS preventative, 3) change their own personal negative bias towards condoms.

2. Development of negotiation skills of wives over sexual issues

Since women lack in negotiation skills concerning sexual matters and husbands have a strong influence over contraceptive use, it is necessary for wives to develop these skills in order to change their husbands reluctance to use condoms with them. Family planning providers can be trained to counsel their clients in negotiation skills. Special group sessions could be held with clients while they are waiting to see providers in the clinic.

3. Involvement of men in family planning through "male friendly" clinics with counseling of both spouses

Since husbands' maintain much influence over contraceptive choice and tend to be negative towards contraceptive in general and condoms in particular, in order to increase their acceptance, counseling of both spouses in family planning clinics should be promoted. Family planning clinics should be made more "male friendly". For example, special days or times could be set up in clinics for counseling couples or individual husbands. The importance of family planning clinics in the work place should be emphasized also.

4. Development of a multifaceted approach to target men for sexual and contraceptive education

To increase male acceptance of contraceptives and of use of condoms with their wives, men should be especially targeted for sexual and contraceptive education which directly addresses the issues of male sexual dominance, the need for female sexual empowerment and the cooperative sharing of such decisions.

5. Introduction of female condoms in family planning clinics in conjunction with depots for special populations

To avoid the stigma already associated with condoms, the female condom should be introduced for use in clinics in conjunction with depots targeting other specific users such as people living with AIDS and commercial sex workers. All public health education should emphasize the use of female condoms between married couples so that it would be associated with the family.

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